Focus on the Fisc

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FY 14 BUDGET UPDATE

J. Travis McIlwain, General Govt. Section Director

At the 2/22/2013 Joint Legislative Committee on the Budget (JLCB) meeting, the administration presented the FY 14 Executive Budget Recommendation in the amount of $24.7 B of total expenditures of which $8.2 B is SGF. As testified in committee, the administration utilized various methods to balance the budget including but not limited to: various governmental consolidations, utilizing one-time revenue sources, maximizing various non-SGF means of financing, and various budgetary reductions. The LFO is in the process of analyzing the Executive Budget Recommendation and will provide the legislature a detailed analysis of the budget as HB 1 and all the money bills move throughout the process (Supplemental Appropriations Bill, Capital Outlay, Funds Bill).

FOCUS POINTS

Tobacco Settlement Securitization Refinance

Deborah Vivien, Economist/Fiscal Analyst

The Tobacco Settlement Financing Corporation Board (TSFCB) authorized the solicitation of professionals for the refinancing of the outstanding securitized Tobacco Settlement proceeds of $820 M (original securitization was for $1.2 B), though the final structure of the refinancing is not yet known. If the savings are "frontloaded" over the first years of the restructure, it is estimated that the state will gain access to roughly $60 to 80 million either by the end of FY 13 or the beginning of FY 14 without changing the anticipated date of maturity. If the savings are used to reduce the term of the bonds, the bonds will mature in 2021 instead of 2023 at which time the state will receive the full amount of the Tobacco Settlement proceeds. If the state utilizes the savings annually through 2023, it is expected that the state will gain access to about $10 M per year. The TSFCB must finalize the sale structure that will then be approved by the State Bond Commission and the Joint Legislative Committee on the Budget (JLCB). This process is expected to take a few months. From testimony before the JLCB on the Budget, it is anticipated that these savings will be utilized in the supplemental appropriation in FY 13, but those plans will not be certain until the supplemental bill is filed.

State Bond Commission (SBC) Update

Deborah Vivien, Economist/Fiscal Analyst

The SBC received the final calculation of debt capacity for Net State Tax Supported Debt (NSTSD) of $51 M of debt service or about $600 M in borrowing capacity. The SBC indicated that it will move forward immediately with the sale of $100 M in State Highway Improvement Fund (SHIF) bonds for rural highways and await guidance from the SBC Executive Committee on the optimum structure of future debt obligations. Other savings measures that were discussed included the possibility of restructuring some of the existing GO debt using mechanisms that have not yet been decided but are expected to make $100 M - $120 M available to the state in FY 14. Also, the SBC considered a call modification of certain Revenue bonds in exchange for a payment of about $12 M and the possibility of a new Transportation Infrastructure Finance & Innovation Act (TIFIA) loan from the U.S. Department of Transportation, which would consolidate the Senior Lien debt and the existing TIFIA loan utilizing a lower rate. According to DOTD, this transaction would also save an estimated $87 M in debt service obligations under the lower rate (though details concerning this estimate are not clear) and move about $3.6 M in debt service from under the debt limit as the Senior Lien debt would no longer be considered NSTSD. It is not certain whether these savings measures will provide additional revenue for supplemental appropriation in FY 13 or for general appropriation in FY 14 upon implementation, though the timing for all but the $100 M in SHIF bond transaction seems more likely to materialize in FY 14.

Earl K. Long Medical Center (EKL) Closure

Jennifer Katzman, Fiscal Analyst

Transition & Financing: In February 2010, LSU entered into a cooperative endeavor agreement (CEA) with Our Lady of the Lake (OLOL) for operation of EKL's inpatient indigent populations with the exclusion of OB/GYN services and prisoner care. OLOL is adding 100-140 new inpatient beds and plans to expand Graduate Medical Education (GME) once it assumes EKL's business. Under this arrangement, in addition to quarterly advance UPL payments for the upfront care costs of servicing LA's indigent populations, the Dept. of Health & Hospitals (DHH) has agreed to reimburse OLOL for 100% of UCC costs and 95% of Medicaid costs for inpatient services.

Closure of EKL and the transition of inpatient services were originally scheduled to take place in November 2013 (FY 14); however, with the reduction in FMAP rates in FY 13, HCSD is currently negotiating with OLOL to advance this transition date to take place in FY 13 by 4/15/2013. This will allow HCSD to close EKL ahead of schedule and save on labor and operational costs. In addition to amending the CEA in order to advance the transition date, HCSD is also

negotiating with OLOL to take over operation and management of EKL's outpatient clinics. Financing rates and amounts paid to OLOL for operation of EKL's outpatient clinics is still being negotiated between DHH and OLOL; however, federal reimbursement of Medicaid and UCC costs through OLOL for the outpatient clinics will require approval of the Centers for Medicare & Medicaid Services (CMS).

Personnel Layoffs: There are 964 T.O. appropriated for EKL in FY 13, however, according to HCSD, due to destabilization from the FMAP reductions, there are only 834 personnel employed at EKL as of 1/30/2013. Once EKL closes and services transition to OLOL, these 834 personnel will be laid off from state employment (565 full-time, 269 part-time). HCSD plans to submit its finalized layoff plan to the state Civil Service Commission at its 3/6/2013 hearing with a projected layoff date of 4/14/2013. OLOL is obligated under the CEA to give EKL's current employees first consideration for employment.

Prisoner Care: Prisoner care is not contemplated under the existing CEA with OLOL. As a result, HCSD's current plans for EKL prisoner care is to work with the Dept. of Corrections to increase utilization of on-site prison clinics and telemedicine, and transport prisoners to Lallie Kemp Regional Medical Center if deemed medically necessary. In FY 12, EKL had 2,130 prisoner visits and expended approximately $11.7 M ($8.5 M budgeted for FY 13). Prisoner care is reimbursed with 100% SGF. For further details on statewide prisoner health care costs and procedures, see article titled "*Correctional Care*."

Mental Health Emergency Room Extension (MHERE) Unit: Currently at EKL, the Capital Area Human Services District (CAHSD) owns and operates a 10-bed MHERE unit attached to the Emergency Department. This unit redirects critical behavioral health patients that enter the ER to a more stable environment so that they do not immobilize needed ER beds that are necessary for other emergency health issues. Once the patients are stabilized, CAHSD arranges for follow-up care in the community or residential treatment as necessary. Based on information provided by CAHSD, the MHERE unit served more than 3,400 patients and saved the state approximately $20.6 M by avoiding hospitalizations for 68% of the patients admitted to the emergency department. Once EKL closes, the MHERE unit will not have a place to operate though CAHSD is working to find a new location. Through emergency rule, CAHSD anticipates being able to operate under a new crisis receiving center license that does not require proximity to a hospital or emergency department by 3/20/2013.

Closing Costs: Liabilities for which the state will still be responsible after EKL closes include retirees' insurance premiums & health insurance (estimated at $3,607,610 for all current and eligible retirees as of 6/30/2013) and termination pay (estimated at $3,917,048 under Civil Service rule 11.10). Currently, retiree insurance is funded through various payor mixes such as Medicaid and UCC, which have a Federal match component to mitigate state expenditures. Once EKL closes, these revenues will no longer be available for EKL's retirees, HCSD will have to pay retiree insurance with 100% SGF. In addition to these costs, until the state is able to sell or lease the property, certain costs associated with security, maintenance, and insurance with the Office of Risk Management (ORM) will continue to be paid by LSU HCSD (estimated at approximately $1,062,000 annually by HCSD). The market value of EKL is currently unknown; however, to increase sale potential, the state could choose to demolish the hospital in order to capitalize on land value. According the Office of Facility Planning & Control, it would cost the state an estimated $3,791,552 to demolish EKL's 18 buildings (236,972 square feet), which sit on 14.27 acres of land.

Land Sale Procedure: The LFO has requested confirmation from the Division of Administration's Office of State Lands (OSL) whether the LSU Board of Supervisors has the statutory authority under R.S. 17:3351 to buy, sell or lease its properties without going through OSL. Under this authority, the proceeds of any sales or leases would go to LSU as self-generated revenues and not be deposited directly to the SGF. Outside of R.S. 17:3351, if the state decides to deposit the sale proceeds into the SGF, LSU would have to surplus EKL to the Division of Administration as nonessential immovable property (R.S. 41:140). Nonessential property is defined as "land and immovable structures thereon, the use of which is not indispensable to fulfillment of an agency's legally established functions," including if the "property has been closed, abandoned or neglected by the agency" (LAC 43:XXVII.3101). After the property has been determined nonessential, LSU and the OSL will have to adhere to the following procedures detailed under LAC 43:XXVII.3101-3102:

* OSL and LSU shall execute an agreement transferring EKL to OSL. Copies of this agreement shall be filed with the clerk of court for the Parish of East Baton Rouge.

* OSL must prepare a land management evaluation report giving recommendations for the best use or disposition of the property containing the following: property appraisal by public lands appraiser, a minimum acceptable bid (must be 90% of the appraisal), timber appraisal (if applicable), map &

legal description of the property, recommendations for best use or disposition, and method & reasons for possible sale.

* The report must be filed with the House and Senate Natural Resources committees and the representative and senator in whose district the property is located.

* In order to sell EKL, OSL must receive the written approval of both House and Senate Natural Resources committees within 90 days of the committees receiving the report.

REVENUE

FY 13 Major Revenue Collections Summary Through January 2013
Greg Albrecht, Chief Economist

January marks 7 cash months and approximately 6 accrual months of collections this fiscal year. Overall, January was a decent collections month; but only the second decent month so far this fiscal year. The year-to-date growth of the personal income tax remains ahead of forecast, but the general sales tax is still barely ahead of forecast on an accrual basis and behind forecast on a cash basis. Both of these taxes have been exhibiting a monthly seesaw pattern and a subsequent weak month can pull both of their year-to-date performance records below forecast. The next 2 months will be particularly important for the income tax, as February and March have become large refund months. A string of good months is necessary to make a trend, and the collections of these 2 taxes are still best characterized as erratic.

Although monthly corporate collections tell us little about annual performance and these monthlies exhibit wide variation, the only generally strong tax so far this year has been corporate. Even though January was a negative month, it is still and improvement over prior year. The forecast for this tax is modest and generally good monthlies are encouraging. However, 1/2 to 2/3 of these collections arrive in the last quarter of the fiscal year. Thus, confidence in this tax cannot typically be obtained until late in the fiscal year.

Both severance tax and royalty receipts disappointed in January. As expected, the year-to-date performance of the severance tax has begun to deteriorate relative to prior year as easy monthly comparisons have ended. Royalty receipts continue the weakness they have exhibited all year, likely a result of and weak gas prices, and seem unlikely to meet forecast.

Gaming receipts from riverboats, video poker, and slot machines were weaker in January, diminishing year-to-date growth, but still remaining positive and above forecast. Current performance is based on only 2 good months, but the forecast calls for only very modest growth. While these revenues may not disappoint this year, this discretionary spending still hasn't returned consistently.

Overall, after the 12/13/2012 REC downward forecast revision, total tax revenue for FY 13 is expected to drop by 0.9% from FY 12 actual collections, and general fund tax revenue is expected to drop by 1.1%. This is a year-over-year revenue drop expectation, not just a forecast drop for a given year, and is largely due to sub-par performance of the 2 taxes that largely reflect real-time economic conditions, sales tax (household and business spending) and personal income tax (employment and income generation). Although there has been some improvement mid-way through the fiscal year, it hasn't yet been enough to change the current forecast expectation.

EDUCATION

Impacts on Graduate Medical Education (GME) from Redesign of LA's Public Health Care System
Charley Rome, Fiscal Analyst

The LSU Board of Supervisors (BOS) is overseeing a redesign of LA's Public Health Care System. This redesign is being driven by significant reductions in state and federal funding for public health care services for uninsured and indigent patients. Most of the state hospitals in the Health Care Services Division (HCSD) in south LA are participating with nearby private hospitals to operate HCSD hospitals, provide care to uninsured/indigent patients and provide training to resident physicians. Similarly, the 3 northern state Hospitals under LSU Health Sciences Center Shreveport (LSUHSC-S) are in discussions with potential partners to ensure continued medical education and patient access to care. It is unclear how LSU's health care redesign will affect Graduate Medical Education (GME).

GME refers to formal medical education pursued by individuals who have earned a medical doctor (M.D.) degree. The medical school in New Orleans is accredited to contract its residency program with multiple teaching hospitals to garner access to sufficient volumes and varieties of patients. Historically, the New Orleans medical school has contracted with HCSD's seven public hospitals, related clinics, and some affiliated private hospitals. Through this structure, 813 total resident physicians receive GME training with 433 in the

HCSD hospitals. LSUHSC-S residency training programs are accredited within its university teaching hospitals and some targeted, approved partner-training programs. Through this structure, LSUHSC-S is currently training 536 residents.

According to LSU, the proposed partnerships between HCSD hospitals and private hospitals will continue the current New Orleans residency structure with their new partners. LSU has indicated that the partnerships will ensure access to a greater number of patients than the HCSD hospitals provide and strengthen their GME residency experience.

The details of the residency transition for 6 of the 7 HCSD hospitals are still in development through Memorandums of Understandings outlining the parameters of Cooperative Endeavor Agreements (CEAs) between the following 6 HCSD hospitals and proposed private partners: Interim LSU Hospital - University Medical Center in New Orleans, Leonard J. Chabert, University Medical Center in Lafayette, Walter O. Moss Medical Center, Earl K. Long/Our Lady of the Lake Medical Center, and Bogalusa Medical Center. Negotiations between LSU and proposed private hospital partners are ongoing, and LSU will not release specific information on proposed CEAs between LSU and potential private hospital partners. As such, many factors affecting the proposed health care redesign and GME remain unanswered without access to proposed CEAs.

The following issues and factors will not be known until the CEAs are finalized between LSU and proposed private hospital partners:

Ownership of Residency Slots: The state and LSU currently own and control residency slots. Without access to proposed CEAs, it is unclear who will own and control residency slots under the proposed health care redesign. There is a risk that LA could lose residency slots to other states if LSU and private hospital partners do not meet CEA requirements or either party chooses to end CEAs.

Payment of Residency Stipends and Resident Supervision Costs: LSU currently pays residency stipends and resident supervision costs with funds mostly derived from operation of state hospitals. LSU will continue to pay residency stipends and resident supervision costs under the proposed health care redesign. However, LSU will contract with private partner hospitals for payment of residency stipends and supervision costs for patient care in the proposed health care redesign. If the proposed public private partnership fail, and LSU is unable to find alternative private hospital partners, LSU will have no funding source for residency stipends and resident supervisory costs. LSU must pay these costs even if private hospitals cannot or will not reimburse LSU.

Patient Care Costs: Private partner hospitals will incur additional patient care costs because resident physicians will likely see a large number of uninsured and indigent patients. Without access to proposed CEAs, it is unclear how private partner hospitals will fund additional treatment costs incurred for uninsured and indigent patients under the care of resident physicians practicing in private partner hospitals.

Accreditation Issues: Residency training programs require that resident physicians treat a certain volume of patients. In the state's current system, much of this resident patient volume consists of uninsured and indigent patients. As mentioned above, private hospitals will incur additional costs to treat these uninsured and indigent patients. As such, private hospitals may face economic incentives to provide less care to uninsured and indigent patients. Residency programs may risk loss of accreditation if resident physicians do not treat enough patients in their medical training.

Community Pilots for Early Childhood Network
Mary K. Drago, Education Section Director

The state appropriated approximately $256 M in FY 13 through the Dept. of Education (DOE), Board of Elementary & Secondary Education, Dept. of Children & Family Services and the Dept. of Health & Hospitals from various means of financing for early care and education services for children. The funding is associated with programs such as Early Head Start, Head Start, Early Steps, LA-4 and other public school Pre-K classes. There has been concern about the varying quality, costs and access to these services, prompting the enactment of Act 3 of 2012, the Early Childhood Package. Act 3 requires the state to develop a comprehensive and integrated delivery system for early childhood care and education so there are unified standards, enrollment and funding by 2015. In the future, funding for programs receiving state or federal dollars will be based on performance.

The DOE is proposing 5 pilot networks for implementation of the Early Childhood Package, and will provide support to the pilots from 7/1/2013 to 6/30/2015. The pilots will be selected in Spring 2013. According to the DOE, each network will be comprised of one or more school districts and have a not-for-profit or governmental lead partner that will serve as the fiscal agent. Each pilot will be awarded from $80,000 to $250,000 to help develop the infrastructure for the assessments and enrollment processes, and coordinate resources of the network

partners. It is anticipated the department will use dedicated 8(g) funds from the LA Quality Education Support Fund to provide the awards to the pilots. The pilot networks will agree to do the following: identify children (0-5 years of age) in need of services; adopt development and learning standards; participate in assessments; implement a unified enrollment process for all families; and provide data to support a statewide early childhood information system.

GENERAL GOVERNMENT

Capital Outlay Funding Limitations and Use of CCC Tolls

Deborah Vivien, Economist

Capital outlay projects are paid through the Capital Outlay Escrow Fund (COEF). Deposits into the fund include bond proceeds, cash, SGR, Statutory Dedications and Federal funds. In the past, there has been sufficient cash on hand and borrowing capacity to keep lines of credit funded between bond sales, even if the funds were not originally designated for those projects. In other words, cash on hand might be used temporarily for other projects but replenished with bond proceeds or other means at a later date. However, at this time, there is little money in the COEF beyond authorized cash lines of credit (about $27 M for DOTD projects and $68 M for Facility Planning) to allow cash flow, and it appears that the debt limit will soon constrain future borrowing capacity. SGF revenue from the 2007 and 2008 surpluses were deposited into the COEF providing liquidity when bond proceeds were running low, which is a major reason why this funding issue has not appeared in recent years. However, through the issuance of cash lines of credit, the surplus funds have now been depleted to the point that the necessary liquidity is no longer available. Because of the lack of cash flow and limited borrowing capacity brought about by decreases in state revenue, when available cash is now used to fund lines of credit for projects unrelated to that cash, replenishment may not occur in a timely manner. Thus, projects originally specified to be completed with funds deposited into the COEF may go unfunded.

One example of this occurrence is the recent transfer of a portion of the trust fund balance of toll collections from the Crescent City Connection (CCC), which was deposited into the COEF in January 2013. The CCC tolls were deposited into a trust to pay bonds related to the CCC. Tolls that accumulated in the trust after the bonds were paid as of 12/31/2012 ($31,278,965) were disbursed to the following funds: Capital Outlay Escrow Fund ($11,208,737), DOTD Operations ($12,788,759), and the Crescent City Transition Fund ($7,281,469). According to Act 866 of 2012, the CCC tolls in excess of those required to pay the CCC indebtedness as of 12/31/2012 had a specific purpose. The first $4 M would be appropriated for use by DOTD to fund the ferry service formerly operated by the CCC Division within DOTD. The balance was to be appropriated through the newly created Crescent City Transition Fund for use by DOTD under the advisory of the New Orleans Regional Planning Commission for lighting and maintenance of the approaches and connecting arteries. In January 2013, 77% of the toll trust fund balance was transferred to the DOTD budget and COEF to cover existing operating expenses and capital projects identified by DOTD as being related to the CCCD.

Once these toll funds were deposited into the COEF, they were used with other DOTD funding and for all DOTD projects. As stated above, typically, these funds are replaced as needed with either bond proceeds from additional bond sales or with cash. However, new bond issues appear to be constrained by the debt limit and it is doubtful that cash is available to replace the funds if they are needed.

Note: Per Act 866 of 2012, the first $10 M collected in new tolls (after 12/31/2012) will be deposited annually into the Crescent City Capital Projects Fund and may be used to secure bond funding. If there is no underlying guarantee or payment by the state, this would not be considered Net State Tax Supported Debt and therefore not impacted by the debt limit. These bond proceeds could be used to fund allowable CCC projects, some of which may be those projects that were not able to be completed with old toll money, though these projects technically would have been funded twice using this mechanism.

Cash Balance Plan – Social Security Equivalency Test

J. Travis McIlwain, General Govt. Section Director

In the Fall 2012, the Division of Administration (DOA) (through its contract attorney Baker Donelson) submitted a request to the Internal Revenue Service (IRS) on whether or not the Cash Balance Plan (CBP) as it was enacted in Act 483 of 2012 is an equivalent retirement program to Social Security. The current Defined Benefit Plan (DBP) is considered a social security equivalent plan. Thus, all state employees participating in the traditional state pension plan do not pay the Federal Insurance Contributions Act (FICA) tax nor does the state pay the employer portion of the FICA tax (6.2% employee portion/6.2% employee portion, 12.4% total).

In its letter to the IRS, the DOA contract attorney argues that the CBP meets the equivalency test under the defined contribution components. One of

the test components requires that allocations to the employee's account (exclusive of earnings) must equal at least 7.5% of the employee's compensation. The DOA contract attorney argues the CBP meets this requirement due to the fact that member's account will be credited with an amount equal to 12%. However, the CBP could be considered a type of DBP with some defined compensation plan components. Nebraska is the only other state in the country with an existing CBP (since 2003) and its participating members pay into social security. In addition, Kansas enacted legislation creating a CBP, which becomes effective in 2015. All of the Kansas participating CBP members will contribute to FICA as do its current DBP members.

If the plan is not considered a social security equivalent plan, then the state and its CBP participants will be required to pay the FICA tax. Due to this plan rolling out to newly hired employees on 7/1/2013, the DOA has requested an expedited ruling from the IRS. Although no social security equivalency for the CBP has been ruled on by the IRS to date, the DOA anticipates the plan going into effect on 7/1/2013 regardless if a ruling has been issued. The DOA anticipates a Spring/Summer 2013 ruling.

Note: There may be an indeterminable fiscal impact if the IRS rules that the CBP is not a social security equivalent retirement plan. If the CBP begins in July 2013 and the IRS ruling is completed after the plan has begun, the retirement systems believe the 12.4% will be retroactively due from the time at which the ruling is made back to 7/1/2013 (enactment date of CBP). For example, if employee John Doe starts an entry level job making $2,500/month ($30,000/year) and the ruling is issued in January 2013, the systems believe the employee and state will be required to contribute $930 each to SS for back FICA tax due from July 2013 to December 2013. The DOA believes this will not be an issue as they anticipate a ruling prior to 7/1/2013.

For example, if the plan goes into effect on 7/1/2013 without a ruling, based upon the latest actuarial valuation of the LASERS, CBP participating individuals will be contributing 8% and the state will be paying 27.8% (normal cost – 2.3%, UAL portion – 25.5%). If the IRS rules that the CBP is not a social security equivalent plan, then the state and employee will be required to pay the FICA tax. Thus, the cost of the CBP is higher than originally anticipated for the employee and the state. CBP participating individuals will be contributing 8% and paying the 6.2% FICA tax (14.2% total), while the state will paying 34% (2.3% - normal cost, 25.5% - UAL, 6.2% - FICA). For context, the total employer contribution projected in FY 14 for the traditional rank & file defined benefit participants as projected in Fall 2012 by their actuary is 31.3% for LASERS (25.5% UAL/5.8% employer normal cost). *Essentially, if the IRS ruled against social security equivalency for the CBP, it will cost the state more on an aggregate basis than the existing traditional rank & file LASERS DBP.*

FY 12 Calculated Surplus
Greg Albrecht, Chief Economist
Travis McIlwain, General Govt. Section Director

At the October 2012 JLCB meeting, the Division of Administration (DOA) reported a preliminary FY 12 year-end budget surplus of approximately $143.3 M. However, at the January 2013 JLCB meeting, the DOA reported a FY 12 year-end surplus of approximately $113.2 M, which is approximately $30.1 M less than originally anticipated. The majority of the difference is due to $25.2 M of pending fund transfers associated with Executive Order BJ 2011 – 25 (December 2011) that have not taken place to date and $4.95 M of Average Wholesale Price (AWP) legal settlements that have been collected by the Attorney General, but have not been officially transferred into the SGF.

Executive Order BJ 2011-25 was signed in December 2011 in an effort to resolve the FY 12 mid-year budget deficit problem of approximately $251.3 M. Approximately $38.2 M of this FY 11 SGF problem is funded by cutting various statutorily dedicated appropriations and transferring these funds to the SGF. As mentioned above, $25.2 M of these transfers has not taken place due to lack of funds for the State Treasury to transfer. Because the Executive Order has not expired, these resources should be transferred into the SGF. However, based upon the past fiscal year's revenue collections and expenditures of these Statutory Dedications, the excess funds may not be available for the State Treasury to transfer. The majority of the funds not transferred are from the Transportation Trust Fund (TTF – Regular) in the amount of $24,418,675. These anticipated excess funds resulting from the FY 11 mid-year reduction plan never materialized. In fact, even after the $24.4 M operating budget reduction in TTF – Regular in December 2011, DOTD did not expend up to appropriated budget authority due to lack of revenue collections. In addition, the TTF – Regular prior year cash carry over into FY 13 was approximately $0.9 M, while the 5-year average of prior year cash carry over into the next fiscal year has averaged $68.5 M (FY 08 - $79.2 M, FY 09 - $54.8 M, FY 10 - $104 M, FY 11 - $53.9 M, FY 12- $50.6 M, FY 13 - $0.9 M). *See Alan Boxberger's write-up in this edition of Focus on the Fisc for details concerning the lack of TTF resources available for transfer.*

Act 597 of 2012 provides for the transfer of legal settlement proceeds from 6 identified AWP legal cases listed in the Act to be transferred into the SGF (effective in FY 12). According to the DOJ, the total

amount of these 6 cases is $27.25 M of which $4.95 M will essentially come from DOJ's settlement proceeds.

Act 597 also required the Consensus Revenue Estimating Conference (REC) to promulgate FY 12 actual revenue collections. The treasurer is then directed to transfer the difference between actual collections and those officially forecast for FY 12 on 4/24/2012, up to a maximum of $204.7 M into the Budget Stabilization Fund. This language effectively pays back any unnecessary amount that was withdrawn from the Fund late in FY 12 to support the FY 12 budget. The amount of excess collections subject to the provisions of Act 597 is $125.5 M. To date, the REC has not yet addressed this issue, and this excess is now a component of the FY 12 year-end surplus.

Traditionally, the REC recognizes and designates surplus balances as nonrecurring revenue. Funds so designated become subject to the constitutional provisions for use of officially designated nonrecurring money: 25% to the Budget Stabilization Fund, and various forms of debt retirement and capital outlay. The administration had indicated that it wanted to use $94 M of these excess collections to help resolve the current fiscal year federal Medicaid funding problem that impacted the FY13 budget shortly after its enactment.

Note: After the FY 12 prior year surplus had already been calculated, the DOJ/State Treasury transferred $3 M of its $4.95 M into the SGF. To date, the remaining portion to be transferred from these 6 cases is $1.95 M.

Inability to Withdraw Transportation Trust Fund (TTF) Proceeds (FY 12 Deficit Reduction Plan)
Alan Boxberger, Fiscal Analyst

Pursuant to the FY 12 mid-year deficit reduction plan approved by the Joint Legislative Committee on the Budget (JLCB) on 12/16/2011, the LA Department of Transportation & Development's operating budget realized a reduction of $24.4 M of TTF-Regular expenditure authority. These funds were to be used to offset SGF reductions pursuant to R.S. 39:75(C)(2)(b), wherein the Governor may, with approval of the JLCB, exercise a 5% reduction in Statutory Dedications in order to offset any projected deficit caused by changes in the state's revenue forecast.

The State Treasury attempted to withdraw $24.4 M of TTF cash during FY 12 pursuant to R.S. 39:75(C)(2)(e). However, actual TTF revenue collections during FY 12 did not equal or exceed the department's budget authority after the deficit reduction action. Accordingly, the state treasurer was unable to withdraw the cash due to non-collection of revenues.

The State Treasury reports that it interprets Executive Order BJ 2001-25 and subsequent JLCB action on the mid-year deficit reduction to be open-ended. Thus, the State Treasury will continue monitoring TTF revenue collections in perpetuity until such time as it is able to extract the assigned $24.3 M in TTF for deposit into the SGF. This action can be done in whole, if revenues exceed appropriation authority by more than $24.3 M, or incrementally over a number of fiscal years if excess collections fall below the $24.3 M threshold. The withdrawal can also occur in any fiscal year wherein departmental expenditures fall below the appropriation authority assuming sufficient revenues support the withdrawal. Barring additional legislative or executive action to eliminate the obligation, the $24.3 M charge against the TTF will be carried forward as a legal obligation of the department until such time as there is sufficient cash to fully liquidate the balance due. *Based upon FY 12 revenue collections and expenditures, it appears that this $24.3 M transfer may not take place in FY 13 or in future fiscal years unless DOTD collects TTF revenues in excess of current expenditure authority.*

Act 597 Action Not Materialized (Update)
Travis McIlwain, General Govt. Section Director

In the January *Focus on the Fisc*, the LFO indicated that there were approximately $281.4 M of funds bill resources that have not been transferred to the SGF, Medical Assistance Trust Fund (MATF) or Overcollections Fund that have been appropriated in FY 12 & FY 13. Based upon updated information provided to the LFO by the State Treasury, to date there are approximately $278.4 M of funds bill resources that have not been transferred to the SGF, MATF or Overcollections Fund that have been appropriated in FY 12 & FY 13.

Act 597 transfers approximately $258.5 M from various resources into the SGF. *To date, there is approximately $67.7 M (or 26%) of resources that have been transferred into the SGF for expenditure*. Some of the significant funding items ***not*** transferred include: $56 M – Risk Management's Self-Insurance Fund; $10 M – Proceeds from NOAH sale; $1.95 M – Proceeds from 6 Average Wholesale Price (AWP) settlements *(State Treasury received $3 M from the Department of Justice in January)*; $78.3 M – bond repayments; and $10 M – FEMA Reimbursements.

Act 597 transfers approximately $79.5 M from various resources into the MATF. *To date, there is approximately $42.9 M (54%) of resources that have been transferred into the MATF for expenditure*. Some of the significant funding items ***not*** transferred include: $20 M – Ernest Morial Exhibition Hall Authority; $25.9 M – bond repayments; and $6.7 M – various fund transfers.

Note: A large portion of the $42.9 M transferred into the MATF comes from collecting $38 M of Average Wholesale Price (AWP) legal settlements. Act 13 (HB 1) only appropriates $22 M of these resources from MATF within DHH.

Act 597 directs the state treasurer to transfer $41.1 M into the Overcollections Fund. *To date, there is approximately $6.1 M (15%) of resources that have been transferred into the Overcollections Fund for expenditure.* The significant funding item not transferred includes: $35 M – Sale/lease of NOAH. In addition to NOAH, Act 597 directs the state treasurer to transfer proceeds from the sale of the former DOI building site, excess receipts over $10 M from FEMA reimbursements and excess receipts over $56 M from the Self-Insurance Fund. These additional items have not taken place and are not currently included in the FY 13 operating budget.

Note: To the extent these Act 597 resources do not materialize, the FY 13 SGF budget could finish the fiscal year in a deficit posture unless expenditures are reduced or another resource is identified.

Bond Premium Replacement
J. Travis McIlwain, General Govt. Section Director

One of the major funding sources supporting the FY 13 budget is an approximately $68.2 M bond premium received at the end of FY 12. In its monthly Fiscal Status Statement presented to the Joint Legislative Committee on the Budget (JLCB), the Division of Administration (DOA) "nets" this revenue source against the FY 13 debt service payment. Thus, the current projected debt service payment (as presented in the Fiscal Status Statement) is approximately $235.4 M as opposed to the actual projected FY 13 payment of approximately $304 M. This bond premium resource will likely require additional SGF or another unidentified source funds in FY 14 in order to pay the projected FY 14 General Obligation (GO) debt service payment. According to the latest GO debt service payment schedule for FY 14, the anticipated payment is projected to be $324.7 M. This projection is subject to change as some of the debt instruments have variable interest rates.

Included within the FY 14 Continuation Budget, the DOA is assuming an additional SGF need of approximately $90 M for GO debt service payments in FY 14, which equates to an FY 14 payment of approximately $324.7 M. The additional $90 M is calculated as follows: $68.2 M – replacing bond premium revenue with SGF (discussed above); $21.9 M – additional SGF need to meet current projected FY 14 debt service payment, which is ultimately projected to increase from $304 M in FY 13 to $324 M in FY 14 (see table below).

FY 13 Funding Resources:	
FY 12 Bond Premium	$68.2 M
FY 13 SGF	$235.4 M
Total Projected GO Payment	$303.6 M

FY 14 Potential Funding Resource:	
FY 14 SGF	$324.7 M
FY 14 Projected GO Payment	$324.7 M

Based upon the tables above, the FY 14 GO Debt Service Payment will require approximately $90 M more in SGF resources than what is currently being allocated in the current year, FY 13. The DOA has accounted for this in the FY 14 Continuation Budget.

Note: The FY 14 recommended SGF for GO Debt Service is approximately $338.9 M. According to the Executive Budget documents, the DOA is including an additional $14.2 M for an anticipated bond sale in FY 14. The LFO is in the process of gathering additional information relative to this information.

Transfers from the LA Self-Insurance Fund
Charley Rome, Fiscal Analyst

The LA Office of Risk Management (ORM) maintains a self-insurance fund to pay for liability claims against the state and to cover damages to state buildings and property. LA also procures insurance from private insurance companies for liabilities and damages against the state exceeding certain thresholds.

In FY 11 the Legislature transferred $119 M from the state's self-insurance fund to other funds for uses unrelated to paying insurance claims. Act 597 of 2012 authorized transfer of an additional $56 M from the state's self-insurance fund to the SGF for uses unrelated to paying insurance claims. The $56 M transfer from the self-insurance fund in FY13 has not taken place at the time of this publication due to ongoing litigation between the state and some insurance companies related to state insurance claims disputed by these carriers.

These transfers from LA's self-insurance fund may threaten the state's ability to pay for disaster related projects to repair and replace state assets and facilities in the future. Transfers from the state's self-insurance fund jeopardize funding of disaster related state projects in the future because the Federal Emergency Management Agency (FEMA) offsets federal disaster payments to LA by amounts of insurance claim proceeds paid to LA by the state's private insurance carriers for such disaster related projects. As such, amounts transferred from the fund may not be

available to pay for disaster related state projects in the future.

The LFO is unable to identify which state disaster related projects might face funding shortfalls in the future with information currently available. Furthermore, the LFO is unable to determine when state disaster projects may face funding shortfalls due to transfers from the state's self-insurance fund with information currently available. The LFO has requested detailed information from ORM to ascertain which state disaster project might be affected and when they might be affected. ORM has not provided the information requested by the LFO at the time of this publication. The LFO will provide future updates relative to information obtained from ORM and impacts to state disaster related projects in the future.

HEALTH & HOSPITALS

Correctional Care
Stephanie Blanchard, Fiscal Analyst
Jennifer Katzman, Fiscal Analyst

Corrections Expenditures and Process: The amount budgeted for health care in the Department of Corrections (DOC) in FY 13 is $45,313,460. This funding is allocated to each of the 8 facilities. Pharmacy operations are budgeted by region (LA State Penitentiary and Elayn Hunt Correctional Center). The amount budgeted for pharmaceuticals in FY 13 is $4,404,689 and is included in the total health care budget.

For Local Housing of State Offenders, the per diem of $24.39 per offender per day is a flat rate paid for operational costs. Local Housing of State Offenders is budgeted $1.5 M for extraordinary medical expenses in the local facilities, and for Orleans Parish Prison only, local housing is budgeted $2 per day for medical cares and $7 per day for psychiatric care at the prison.

In FY 12, there were 21,606 DOC hospital or telemedicine visits. Of this amount, 15,300 were scheduled specialty visits, 1,948 were emergency visits, 811 were emergency room admissions, 210 were elective admissions, and 3,337 were telemedicine appointments. Scheduled specialty visits include visits to specialist's clinics and/or diagnostic testing. Elective admissions include scheduled surgeries. Telemedicine appointments occur on-site with the use to technology, instead of having to go off-site. This information does not include the Local Housing of State Adult Offenders in local correctional facilities.

Access to Care and Clinical Services is a service that provides access to health care, routine and emergent on a daily basis by the DOC. This service is provided on designated days and times throughout the week at each facility. Primary care physicians are also available either on-site or on call.

HCSD Expenditures & Process: For the 7 HCSD hospitals and the prisons and jails in the south, all requests for routine appointments or tests are routed through the HCSD Central Prisoner Scheduling Office (CPSO). CPSO reviews all requests for appropriateness and to assure all pre-testing and information is complete and to determine if the initial evaluation can be done using telemedicine or whether a clinical or hospital visit is required. Depending on this determination, CPSO will schedule the necessary appointment via telemedicine or refer to the closest clinic. In FY 13, the total cost for the prisoner telemedicine program at HCSD is about $900,000. The budget provides for the physician providers from the School of Medicine, the physician's clinical staff, the technical staff and network that the telemedicine clinics require to operate, and some of the costs of the review functions at the CPSO. According to HCSD, the total number of telemedicine visits in 2012 was 4,573. As a result of the telemedicine clinics, which started in FY 10, the total number of prisoner face-to-face visits has decreased by 6,563 at the HCSD hospitals and clinics. In FY 12, $29,230,763 in SGF was expended on prisoner care at HCSD, and there is currently $26 M in prisoner health care costs projected for FY 13. As these costs are unallowable for reimbursement through Medicaid or DSH, they are 100% state funded.

Southeast LA Hospital (SELH) Privatization Update
Jennifer Katzman, Fiscal Analyst

On 12/3/2012, a cooperative endeavor agreement (CEA) was signed between DHH and Meridian Behavioral Health Services for the continuing operation of SELH in Mandeville beginning 1/2/2013 through 1/1/2016. SELH was originally scheduled to close in FY 13 due to an allocated cut as a result of the federally mandated FMAP reduction. In anticipation of closure, 60 intermediate adult beds transferred to Central LA State Hospital (CLSH), 34 to Eastern LA Mental Health System (ELMHS), 8 to River Oaks Hospital, 8 to Community Care Hospital, and 8 to the Bogalusa Medical Center in October of 2012 (118 beds total). DHH conservatively estimated an initial SGF savings of $555,893 ($1.6 M total MOF) as a result of personnel reductions. As a result of privatization, OBH anticipates that SELH's budget will be reduced as follows in FY 14:

	FY 13 Appropriated	FY 14 Requested
SGF	$9,088,467	$5,578,849
IAT:	$38,066,523	$0
Medicaid	*$2,000,000*	*$0*
UCC	*$35,436,523*	*$0*
Other	*$630,000*	*$0*
SGR	$3,146,893	$0
Federal	$681,247	$438,119
Total	**$50,983,130**	**$6,016,968**

Note: In the FY 13 mid-year cut, $8 M in IAT from UCC was transferred to ELMHS & CLSH in order to fund the transferred beds. The $6 M requested for FY 14 is to make continued payments on ORM premiums, OGB retiree insurance, and maintenance under landowner liability (e.g. underground storage tanks for water, fuel & diesel) and for 6 T.O. that are performing continuing maintenance and close-out. This will result in an overall reduction of approximately $37 M to OBH in FY 14.

Under the CEA, Meridian staffs the remaining 58 beds including: 16 acute adult beds, 22 acute adolescent beds, and 20 adolescent DNP (Developmental Neuropsychiatric Program) beds at SELH. As a result of privatization, the following classified 547 T.O. were eliminated from state employment as of 1/2/2013:

* 51 probational positions (3 were terminated or resigned prior to 12/9/2012)
* 328 permanent positions (2 individuals resigned prior to 1/2/2013)
* 35 vacant positions
* 133 positions were transferred to ELMHS & CLSH (only 40 were filled)

According to DHH, of the employees laid off, Meridian rehired 125 former SELH employees. Under the CEA, Meridian receives payments for Medicaid services via the Statewide Management Organization (SMO) under the LA Behavioral Health Partnership. The state will also pay Meridian a per diem rate of $581.11 for uninsured patients not covered under Medicaid, Medicare, or a commercial payor and for service costs not fully covered by the SMO. The average cost per day at SELH before privatization was approximately $826, which generates a savings of $244.89 per patient/per day, or a maximum of $5.2 M annually if Meridian maintains a 100% daily census of uninsured patients.

LSU Hospital Reductions & Partnerships Update
Jennifer Katzman, Fiscal Analyst

LSU intends to partner with community and private providers to eliminate the need for hospital bed and service reductions (originally estimated at approximately $59.3 M SGF). Currently, there is a Memorandum of Understanding (MOU) in place with the following private non-profit hospitals (the "lessees") for the HCSD hospitals listed below:

* University Medical Center (UMC) - Lafayette General (Lafayette)
* Interim LA Hospital/University Medical Center (ILH) - LA Children's Medical Center (New Orleans)
* L. J. Chabert (LJC) - Ochsner Health System & Terrebonne General Medical Center (Houma)
* Earl K. Long (EKL) - Our Lady of the Lake (Baton Rouge)
* W.O. Moss (WOM) - Lake Charles Memorial (Lake Charles)

According to the MOUs, each private organization will lease and operate the state facilities via a cooperative endeavor agreement (CEA) to be signed by March 2013. The MOUs with UMC, ILH, and LJC were amended on 2/1/2013 in order to delete the milestone payments owed by the lessees to LSU in FY 13. According to LSU, due to high attrition in the hospitals resulting from the hospital partnership negotiations, LSU's costs are lower than anticipated and it will no longer need the milestone payments in FY 13. The MOU with Our Lady of the Lake (OLOL) emphasizes amending the current CEA that has been in place since February 2010 in order to make the move from Earl K. Long (EKL) to OLOL by 4/15/2013 instead of November of 2014. This MOU also contemplates that the operation of all of EKL's outpatient clinics will now be undertaken by OLOL. The LSU Board of Supervisors approved the MOU between WOM and Lake Charles Memorial on 2/1/2013. There are currently no MOUs developed between private partners and Washington/St. Tammany Regional Medical Center or Lallie Kemp Regional Medical Center. According to testimony by LSU before the Joint Legislative Committee on the Budget (JLCB), it is LSU's intent to retain Lallie Kemp as a safety net hospital and not lease it to a private partner. The LFO will continue to monitor current and future partnerships as they develop.

New Criteria for the Family Flexible Funds (formerly Cash Subsidy Program)
Patrice Thomas, Fiscal Analyst

The mid-year deficit reduction decreased $170,280 in SGF from the Flexible Family Fund Program (FFFP). The program provides a small stipend of $258 per month to assist families with children with severe or profound disabilities to offset the extraordinary costs of maintaining a child in their own home in the community. The budget reduction implements new eligibility criteria for the FFFP. Previously, the only criteria to receive Flexible Family Funds (FFF) was having a severe or profound disability as outlined in R.S. 28:451.1-455.2. Under the new criteria, children

whose family income exceeds 650% of the Federal Poverty Level (which is an annual income of almost $150,000 for a family of 4) will no longer be eligible for the program. Also, children who receive home and community-based Medicaid waiver services (Children's Choice or NOW) will no longer be eligible for the program. Therefore, children receiving waiver services will not be able to receive both waiver services and FFF. These changes apply to children currently receiving FFF as well as to new children applying.

The Office for Citizens with Developmental Disabilities (OCDD) reports that there are 1,563 slots offered for FFF. As of January 2013, 1,287 families were receiving FFF and 276 slots were vacant. Before implementation of the new criteria, OCDD estimated that approximately 55 families will become ineligible to receive FFF under the new financial eligibility criteria or that will choose to forego the FFF to stay in a waiver slot ($170,280 = 55 families x $258 per month x 12 months). So far, a total of 34 families have become ineligible to receive FFF. Another 87 families previously receiving FFF did not submit the required financial documentation to qualify under the new criteria. Therefore, a total of 121 children and their families no longer receive FFF. Any savings above the $170,280 generated by implementing the new eligibility criteria in the FFFP will be used to address the waiting list of the program with the 276 vacant slots.

LA Behavioral Health Partnership (LBHP) Status Update
Jennifer Katzman, Fiscal Analyst

Under the LA Behavioral Health Partnership (LBHP), services are managed and coordinated by a single managed care entity known as the State Management Organization (SMO), which was awarded to Magellan Health Services. Magellan is responsible for providing behavioral health services to an estimated 100,000 adults and 50,000 children, including 2,400 in the Coordinated System of Care (CSoC) once the LBHP is implemented statewide in FY 14. The SMO enrolls members in need of services, enrolls Medicaid providers to deliver services, and manage all services for providers.

Services and treatments covered under the LBHP include Early Periodic Screening, Diagnosis, & Treatment (EPSDT) for medically necessary mental health and addiction treatments for children, Psychiatric Residential Treatment Facilities (PRTF) & Therapeutic Group Homes (TGH) for youth under 21, school-based behavioral health services, and adult behavioral health services including major mental disorders and addiction services. Excluded adult populations include: refugee cash and medical assistance programs, tuberculosis populations, Qualified Disabled Working Individuals, alien emergency room services, public and private ICF/MR services, low income subsidies (welfare), family planning, public or private ICF/DD services, or Greater New Orleans Community Health Connection (GNOCHC) services. Also excluded are some adult populations with some other form of insurance that are not dually diagnosed, including Long Term Care co-insured, persons in PACE or Social Security's Supplemental Security Income (SSI) program, adults under LaCHIP Phase IV, and persons with Medicaid coverage of Medicare Part B including Specialized Low-Income Medicare Beneficiaries (SLMB), Qualified Medicare Beneficiaries (QMB), and Qualified Individuals-1. The same exclusions apply for children's populations with the exception of ICF/MR and ICF/DD services for children, which are covered under the LBHP.

In FY 13, there is $384,845,287 allocated in the Medicaid Medical Vendor Payments (MVP) Buy-Ins Program via a selective services 1915(b) Medicaid waiver for the LBHP. However, according to the most recent Medicaid forecast in December 2012, only $333,303,830 in FY 13 total expenditures is anticipated. As a result, there is an estimated $51,541,457 in excess budget authority allocated to the LBHP for FY 13. According to DHH, the reasons for the difference are 2 month's delay in the start-up of the LBHP and slower than anticipated enrollment of residential providers including therapeutic group homes and psychiatric residential treatment facilities. Additionally, the CSoC has not been implemented in half of the planned service regions.

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